TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bioventus LLC

Respondent Name
Texas A&M University System

MFDR Tracking Number
M4-16-3176-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
June 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $4,950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review the charges in question, Wellcomp agrees with the original recommendation. The provider requested preauthorization for an Osteogenesis stimulator, low density ultrasound noninvasive, HCPCS code E0670. The request was denied on November 24, 2015 by Starr Comprehensive Solutions stating ODG criteria was not met."

Response Submitted by: Wellcomp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2015	E0760	$4,950.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 – Services denied at the time authorization/pre-certification was requested
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600(p)(9) states in pertinent part,

> Non-emergency health care requiring preauthorization includes:
>
> > all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   Review of the submitted medical claim finds the submitted total charge is $4,950.00. Pursuant to applicable Division rules the carrier's denial is supported.

2. The Division finds no additional reimbursement is recommended as insufficient evidence was found to support the requirements of Rule 134.600(p)(9) were met.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.